19 March 2020

Dear Colleagues,

The points below aim to avoid face-to-face consultation, wherever possible, particularly in secondary or tertiary care. This is in attempt to reduce pressure on likely over-stretched hospital services, but also for patient safety; namely keeping vulnerable patients away from potential sources of infection.

It is noted that each locality will have different levels of access to: natriuretic peptide testing in primary care, community heart failure teams, community echo, facilities for remote consultations and referral management. As such it is essential that these are explored fully to ensure that best possible clinical care can be provided to as many patients as possible.

New diagnosis pathway:

Referral management
There are a reasonable number of patients (possibly up to 30%) where the potential benefit of assessment in a specialist service is far outweighed by the challenges (including patient distress) and risks of getting them there. This is irrespective of natriuretic peptide level. Examples of such patents might include those that are housebound (or with extremely poor mobility within e.g. nursing home), are markedly frail or have extensive multiple comorbidity [Note many patients within nursing or care homes will be avoiding social interaction wherever possible and as such likely unable/unwilling to attend]. Symptom management is paramount and pragmatic advice regarding initiation of or up titration of diuretics may be the best strategy of care if there is evidence of fluid overload.

There may be a number of ways that can be considered including advice via Choose & Book (decline appointment), Advice and Guidance or other communication to GP.

Some patients may have had a natriuretic peptide checked, yet are already known to a cardiologist or the heart failure team. In these cases advice can often be made having reviewed patient data without need for new consultation.

NT-proBNP in routine use in primary care
Patients with very high levels of NT-proBNP (>2000 pg/ml) are at highest risk of death or hospitalisation. Prioritisation should be considered to see these patients (if appropriate) in as rapid a time-scale as possible within a specialist service.

Patients with intermediate levels of NT-proBNP (400-2000 pg/ml)
Wherever possible consider managing patients remotely, providing management advice having utilised community echo (if available).

No local NT-proBNP availability or limited use
Triage of patients, including initial telephone consultation may help to decide who can be managed via community pathways and services and who needs more urgent face to face consultation.

Routine follow up of patients with known heart failure
All consultations should initially be by phone if at all possible.

If patients are deteriorating then discussion with community team and or GP to change treatment should be considered.

Face-to-face visit consultation at hospital should be restricted for those patients where the above measures fail to result in improvement of clinical status or cases are extremely complex such that they truly need specialist input.

Hospitalised patients and post discharge review
Prioritise those identified at highest risk e.g. NT-proBNP >2000 pg/ml.

Early post discharge review is important and may help to avoid rehospitalisation. This could be taken forward by community heart failure team or trust based team. Consider providing patients with a blood form as they leave hospital and where possible conducting review by telephone.

Support for community teams and MDTs
Attempts should be made to avoid face to face meetings and ideally access to specialist advice should be provided as frequently and rapidly as possible.

Consider using 'NHS-attend anywhere' or other locally supported technology.

Advice to the community teams will prioritise those patients most at risk and use remote consultation if feasible. Priorities will include:

1. The most symptomatic patients
2. Those deemed at highest risk of admission - crucial to try to keep them out of hospital (including recent discharges and those flagged by specialist team as high risk) **3.** Those approaching end of life, to ensure that there is a decision to pursue only community based treatment, and that DNACPR, palliative care etc. are documented and communicated to other services involved i.e. CMC, EPAACS.

Device follow-up
Remote follow up wherever possible.

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BRITISH SOCIETY FOR HEART FAILURE

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